

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

*11336*

**1. PLACE OF DEATH**

County *Jackson*

Registration District No. *417*

Township *West City*

Primary Registration District No. *3021*

City *West City* (No. *1*)

File No. *119*

Registered No. *119*

St. *West City* Ward *1*

**2. FULL NAME**

(a) Residence. No. *12 S. Liberty* St. *West City* Ward *1*

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

*Male*

**4. COLOR OR RACE**

*White*

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

*Married*

**5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF**

*Lela Kumpeler*

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

*May 31, 1853*

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

*78*

*6*

*12*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

*Retired Farmer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

*Dayton Ohio*

**10. NAME OF FATHER**

*Ed Kumpeler*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Ohio*

**12. MAIDEN NAME OF MOTHER**

*Unknown*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Unknown*

**14.**

INFORMANT

(Address)

*Marcel Kumpeler  
West City, Mo.*

**15.**

FILED

*12/14/31*

*R.M. Stormont*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

*Dec 12, 1931*

17. I HEREBY CERTIFY That I attended deceased from *9-19* 19*31* to *12-12* 19*31* that I last saw *6* alive on *12-12* 19*31* and that death occurred, on the date stated above, at *10 a.* m.

**THE CAUSE OF DEATH WAS AS FOLLOWS**

*Cerebral Hemorrhage*  
*82A*  
*97*  
*Arterio sclerosis*  
(duration) *10* yrs. *4* mos. *4* ds.

**CONTRIBUTORY (SECONDARY)**

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *No* DATE OF *12-12-31*

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Dr. J. H. Humpal*

(Signed) *Dr. J. H. Humpal* M. D.

*14-19-31* (Address) *West City Mo*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

*Frank Memorial Park*

*12/14/31*

**20. UNDERTAKER**

**ADDRESS**

*West City, Ind Co West City*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

